IPC - MENTAL HEALTH AND ADDICTIONS TEAM – REFERRAL FORM

RESET

Phone: (905) 734-1141 x 2222	Fax: (905) 734-1017

IPC Mental Health & Addictions Team REFERRAL FORM		REFERRAL DATE: _____ _____ _____ mm dd yy
Surname:	**First Name:**	**Gender:** **Pronouns:**
Address:	**City:**	**Postal Code:**
Telephone #:	**Date of Birth:**	**OHIP # + version code:**
REFERRING PHYSICIAN / NP Name:	**Telephone #:**	**Fax #:**

REASON(S) FOR REFERRAL	
MENTAL HEALTH NEEDS	**PSYCHOSOCIAL NEEDS**
☐ Depression ☐ Anxiety ☐ Stress ☐ Grief	☐ Housing ☐ Financial ☐ Advocacy ☐ Barriers to Service ☐ Community Connections ☐ Food Insecurity ☐ Employment / Education ☐ Addictions Service Navigation ☐ Other
CURRENT CHALLENGES / CONCERNS: Describe current symptoms/clinical picture precipitating this referral and list any other mental health referrals made with date(s) of referral(s):	
PHQ-9 score:	**GAD-7 score:**

ELIGIBILITY CHECK-LIST	
Please check box if:	
the patient is willing and ready to engage in psychotherapy/counselling	☐
the patient has the cognitive capacity to engage with our services	☐
the patient is aware of any formal diagnoses listed below	☐
the patient has not had any episodes of mania or psychosis in the last 12 months	☐
the patient has not had any suicide attempts in the last 6 months	☐

Please note that our program is not an urgent support service and there's currently a waitlist. We provide up to 12 sessions of psychotherapy in addition to psychosocial support. While we are partners in care of your patient, as their primary care provider you retain primary responsibility over their care.

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HAS THE PATIENT EVER EXPERIENCED ANY OF THE FOLLOWING?					IF YES, DESCRIBE : -date(s) - mm/dd/yy -severity/prevalence -any formal diagnoses
	YES			NO	
	Currently prominent	Improving	Resolved		
Depressive symptoms	○	○	○	○	
Anxiety symptoms	○	○	○	○	
Self-harm	○	○	○	○	
Suicidal ideation	○	○	○	○	
Acute trauma – adult onset	○	○	○	○	
Neurodivergence	○	○	○	○	
Borderline personality disorder	○	○	○	○	
*Developmental delay	○	○	○	○	
*Complex trauma	○	○	○	○	
*OCD	○	○	○	○	
*Manic/hypo manic symptoms	○	○	○	○	
*Psychotic symptoms	○	○	○	○	
*Disordered eating	○	○	○	○	
*Other personality trait/disorders	○	○	○	○	
*Homicidal ideation/violent behaviour	○	○	○	○	
*Psychiatric hospitalization	○	○	○	○	
*Substance use/misuse	○	○	○	○	
*Other Addictions	○	○	○	○	

***If issue is currently prominent, your patient may require more specialized service. Our caseworkers will assist <u>you and/or your patient</u> with system navigation.**

PSYCHIATRIC / PAIN MEDICATION(S)	DATE STARTED mm/dd/yy	COMMENTS: (reason for use, response and compliance)

If the patient has been seen by a psychiatrist, please send consult notes with referral.

FAX COMPLETED FORM (2 PAGES) TO 905-734-1017

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